



**A Guide to Completing the KC-1500 Application
Sections A, B, & C**



A Guide to Completing the KC-1500 Application

For the Elderly and Persons with Disabilities



Sections A, B, & C



This guide was created in partnership with the KanCare Ombudsman Office and the Kansas Department of Health and Environment.

Welcome to the slideshow for Sections A, B, and C of the KanCare Application Guide.

Next, we will cover pages 3 through 10. This is also sections A, B, and C.

For this application, your household includes these people:

- yourself (the primary applicant)
- your legally married spouse, whether they live with you or not
- your partner who lives with you, only if you have children together
- Parents of a minor child

Include all of the people in your household, even if you are not applying for them. Also include household members temporarily living out of the home. Anyone who is not in this list will need to fill out their own application to apply for medical assistance.

The paper clip means we may ask for proof later. Or you can send it now. See the list on page 31.

The paper clip means we may ask for proof later. Or you can send it now. See the list on page 31.

A Tell us about the primary applicant

The primary applicant is the person who needs medical assistance. If the person who needs medical assistance is a child, then the primary applicant is the child's parent or the head of household. Where you see "yourself" and "our" that also means the primary applicant.

Primary applicant: Yourself (or the parent or head of household if the person applying is a child)

Your name
 First name Middle name Last name

Other names used (such as maiden name)

Your contact information

Home address		Mailing address (if different from home address)	
City	State	City	State
Country	ZIP Code	Country	ZIP Code

Check here if you don't have a home address. You still need to give a mailing address.

Home phone _____ Work phone _____

May we contact you by: Email Email address: _____

Text Call phone number: _____

What language do you speak at home? _____ What language do you read and write at home? _____

For help completing this application, call us at 1-800-792-4884 (TTY 1-800-792-4292). The call is free.

This is the third page of the paper application for the Elderly and Persons with Disabilities.

On this page the applicant will see that there is a paper clip icon. Remember that the paperclip icon means we may ask for proof later or the applicant can send it now. See the list on page 31 for more information.

For this application, your household includes these people:

- Yourself (the primary applicant)
- Your legally married spouse, whether they live with you or not
- Your partner who lives with you, **only** if you have children together
- Parents of a minor child

Include **all** of the people in your household, even if you are not applying for them. Also include household members temporarily living out of the home. Anyone who is **not** in this list will need to fill out their own application to apply for medical assistance.



The paper clip means we may ask for proof

For this application, your household includes these people:

The primary applicant, the primary applicant's legally married spouse, whether they live with the primary applicant or not, the primary applicant's partner if they live together and only if they have children together, and parents of a minor child.

Include all of the people in the household, even if the primary applicant is not applying for them. Also include household members temporarily living out of the home.

Anyone who is not in this list will need to fill out their own application to apply for medical assistance.

If married, information for both spouses should be on the application even if one spouse is not applying for medical assistance. If both are applying for medical assistance, then they will only need to use one application.

For nursing home requests and HCBS requests, spouses no longer living in the same household both need to be included on the application.



Primary Applicant Contact Information

Pg. 3, Sec. A

A Tell us about the primary applicant

It now. See the list on page 31.

The primary applicant is the person who needs medical assistance. If the person who needs medical assistance is a child, then the primary applicant is the child's parent or the head of household. Where you see "Yourself" and "You" that also means the primary applicant.

Primary applicant: Yourself (or the parent or head of household if the person applying is a child)

Your name

First name Middle name Last name

Other names used (such as maiden name)

Your contact information

Home address Mailing address (if different from Home address)

City State City State

County ZIP Code County ZIP Code

Check here if you don't have a home address. You still need to give a mailing address.

Home phone Work phone

▶ May we contact you by: Email Email address:

Text Cell phone number:

What language do you speak at home? What language do you read and write at home?

The person who needs assistance should be listed as the primary applicant and continue to be listed as "Person 1" throughout the application. This section can be confusing. If you are helping someone apply for assistance, your information is not needed in this section. Those helping could be nursing facility employees, durable power of attorney, extended family members or friends, etc. This section is only for those who are needing medical assistance.

If the person needing medical assistance is under 18, the primary applicant will be the parent or guardian of the child.

Provide the physical address if possible but the mailing address must be filled out. We will need to be able to send notices to the applicants. If needed, the mailing address can be from a shelter, a friend, a family member, the post office, to name a few. It is really important that the applicant is able to receive notices from us. The applicant may want to use the online application and sign up

for electronic notification to receive notices through the KanCare Self-Service Portal.

People in Nursing homes must have their residential and their mailing address as the Nursing Home. If the applicant wants a copy of mailed notices to be sent to an additional person the applicant can do this on page 27 of the application. Applicants can also contact us for more information on how to appoint a person to receive copies of mailed notices.



Page 4: KC-150: Tell us about yourself and the people in your household

Pg. 4

B Tell us about yourself and the people in your household

- Start with yourself (the primary applicant, or the parent or head of household if the person applying is a child).
- There is room on this application for 3 people. If more than 3 people are in your household, make copies of pages 4-12 before you fill them out. Use the copies to complete persons 4, 5, 6 and so on. Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
What is each person's relationship to you?		
Person 1 is my: Self	Person 2 is my:	Person 3 is my:
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)	/ /	/ /
Marital status:		
<input type="checkbox"/> Married (includes common law, separated)	<input type="checkbox"/> Not married (includes divorced, widowed)	<input type="checkbox"/> Married (includes common law, separated)
<input type="checkbox"/> Married (includes common law, separated)	<input type="checkbox"/> Not married (includes divorced, widowed)	<input type="checkbox"/> Married (includes common law, separated)
<input type="checkbox"/> Married (includes common law, separated)	<input type="checkbox"/> Not married (includes divorced, widowed)	<input type="checkbox"/> Married (includes common law, separated)
Does this person live at the same address as Person 1?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Leave blank	▶ If no, list address:	▶ If no, list address:

This is the fourth page of the paper application for the Elderly and Persons with Disabilities. Next, we will go through each part of the fourth page, or section B.

The individual needing medical assistance should be entered as **“Person 1: Yourself”**

B Tell us about yourself and the people in your household

- Start with yourself (the primary applicant, or the parent or head of household if the person applying is a child).
- There is room on this application for 3 people. If more than 3 people are in your household, make copies of pages 4–12 before you fill them out. Use the copies to complete persons 4, 5, 6 and so on. Attach the copies to your application.

Person 1: Yourself	Person 2	Person 3
First name	First name	First name
Middle name	Middle name	Middle name

Section B continues to ask for information about the Primary applicant, or “Person 1”. This section also asks for information about other people in the household. Again, if the person needing medical assistance is under the age of 18, “Person 1” will be their parent or guardian. The child needing medical assistance will be “Person 2”.

If there is not enough room for everyone in the household to be included, make copies of pages 4-12 before filling them out. Use the copies to complete persons 4, 5, 6, and so on. The applicant will also need to write the names for each person on pages 4-12.

Pg. 4, Sec. B

Person 1: Yourself	Person 2	Person 3
First name	First name	First name
Middle name	Middle name	Middle name
Last name	Last name	Last name
Other names used	Other names used	Other names used
What is each person's relationship to you?		
Person 1 is my: <i>Self</i>	Person 2 is my:	Person 3 is my:
Gender		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (mm/dd/yyyy)		
/ /	/ /	/ /
Marital status		
<input type="checkbox"/> Married (includes common law, separated)	<input type="checkbox"/> Not married (includes divorced, widowed)	<input type="checkbox"/> Married (includes common law, separated)
	<input type="checkbox"/> Not married (includes divorced, widowed)	<input type="checkbox"/> Married (includes common law, separated)
		<input type="checkbox"/> Not married (includes divorced, widowed)
Does this person live at the same address as Person 1?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Leave blank	▶ If no, list address:	▶ If no, list address:

If the primary applicant is married, Person 2 is where the spouse's name will go.

Anyone else living in the household would be entered as Person 3, even if they do not need medical assistance.

The first question asks "What is each person's relationship to you?" If Person 1 is you and Person 2 is your spouse, under "Person 2 is my", you would write "Husband", "Wife", or "Partner".

The next line asks for your gender: Male or Female

Below that, the applicant will put the date of birth for everyone living in the household.

For Marital status: if the applicant is engaged, they would check the box that says "Not married (includes divorced, widowed)".

The last question on page 4 asks "Does this person live at the same address as Person 1?" if the answer is no, list the address they live at.

Be sure to fill out this information for each person listed on the application.



Page 5: KC-1500: Section B continued and Types of Medical Assistance

Pg. 5

B

Person 1 (continued)	Person 2 (continued)	Person 3 (continued)																		
First and last name	First and last name	First and last name																		
Was this person in Kansas foster care on their 18th birthday?																				
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes																		
Medical assistance may help pay for medical and hospital bills, doctor visits, medicine, Medicare premiums, in-home assistance, and nursing home and institutional care.																				
Is this person applying for medical assistance?																				
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes																		
<p>► If yes, what types of medical assistance does each person need? Read the descriptions below. Check the boxes for all programs each person needs. KanCare will tell you if you qualify.</p> <table border="1"> <tr> <td><input type="checkbox"/> Standard Medicaid (with medical card)</td> <td><input type="checkbox"/> Standard Medicaid (with medical card)</td> <td><input type="checkbox"/> Standard Medicaid (with medical card)</td> </tr> <tr> <td><input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility</td> <td><input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility</td> <td><input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility</td> </tr> <tr> <td><input type="checkbox"/> PACE</td> <td><input type="checkbox"/> PACE</td> <td><input type="checkbox"/> PACE</td> </tr> <tr> <td><input type="checkbox"/> Medicare costs only (no other Kansas assistance)</td> <td><input type="checkbox"/> Medicare costs only (no other Kansas assistance)</td> <td><input type="checkbox"/> Medicare costs only (no other Kansas assistance)</td> </tr> <tr> <td><input type="checkbox"/> Medically Needy (Spendingdown)</td> <td><input type="checkbox"/> Medically Needy (Spendingdown)</td> <td><input type="checkbox"/> Medically Needy (Spendingdown)</td> </tr> <tr> <td><input type="checkbox"/> Working Healthy</td> <td><input type="checkbox"/> Working Healthy</td> <td><input type="checkbox"/> Working Healthy</td> </tr> </table>			<input type="checkbox"/> Standard Medicaid (with medical card)	<input type="checkbox"/> Standard Medicaid (with medical card)	<input type="checkbox"/> Standard Medicaid (with medical card)	<input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility	<input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility	<input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility	<input type="checkbox"/> PACE	<input type="checkbox"/> PACE	<input type="checkbox"/> PACE	<input type="checkbox"/> Medicare costs only (no other Kansas assistance)	<input type="checkbox"/> Medicare costs only (no other Kansas assistance)	<input type="checkbox"/> Medicare costs only (no other Kansas assistance)	<input type="checkbox"/> Medically Needy (Spendingdown)	<input type="checkbox"/> Medically Needy (Spendingdown)	<input type="checkbox"/> Medically Needy (Spendingdown)	<input type="checkbox"/> Working Healthy	<input type="checkbox"/> Working Healthy	<input type="checkbox"/> Working Healthy
<input type="checkbox"/> Standard Medicaid (with medical card)	<input type="checkbox"/> Standard Medicaid (with medical card)	<input type="checkbox"/> Standard Medicaid (with medical card)																		
<input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility	<input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility	<input type="checkbox"/> HCBS (includes assisted living) <input type="checkbox"/> Nursing home or other facility																		
<input type="checkbox"/> PACE	<input type="checkbox"/> PACE	<input type="checkbox"/> PACE																		
<input type="checkbox"/> Medicare costs only (no other Kansas assistance)	<input type="checkbox"/> Medicare costs only (no other Kansas assistance)	<input type="checkbox"/> Medicare costs only (no other Kansas assistance)																		
<input type="checkbox"/> Medically Needy (Spendingdown)	<input type="checkbox"/> Medically Needy (Spendingdown)	<input type="checkbox"/> Medically Needy (Spendingdown)																		
<input type="checkbox"/> Working Healthy	<input type="checkbox"/> Working Healthy	<input type="checkbox"/> Working Healthy																		
<p>Types of medical assistance</p> <p>Home and Community Based Services (HCBS) is for children with disabilities and elderly or disabled adults who have a medical need for services in the community so they can live at home or in assisted living.</p> <p>Nursing home or other facility is for children with disabilities and elderly or disabled adults who live in a nursing home, medical or mental health institution, or similar facility for a long-term stay.</p> <p>Program of All-Inclusive Care for the Elderly (PACE) is for adults who live in certain counties and are age 65 or older or are disabled and age 55 or older. Persons who qualify get long-term care coverage through a managed care network so they can stay in the community.</p> <p>Medicare Savings Program (Medicare costs) is for people who have Medicare. This program pays the Medicare Part B premium. It may also pay Medicare co-payments and deductibles.</p> <p>Medically Needy (Spendingdown) is for persons in the community who have a disability or are age 65 or older. It uses medical expenses to "spend down" (lower) your income so you qualify for Medicaid.</p> <p>Working Healthy is for people with disabilities who qualify. It helps them get or keep Medicaid coverage while working.</p>																				
<p>For help completing this application, call us at 1-800-792-4884 (TTY: 1-800-792-4292). The call is free.</p>																				

This is the fifth page of the paper application for the Elderly and Persons with Disabilities. Next, we will go through each part of the fifth page. This is also a continuation of Section B.

B		
Person 1 (continued)	Person 2 (continued)	Person 3 (continued)
First and last name	First and last name	First and last name
Was this person in Kansas foster care on their 18th birthday?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medical assistance may help pay for medical and hospital bills, doctor visits, medicine, Medicare premiums, in-home assistance, and nursing home and institutional care.		
Is this person applying for medical assistance?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>► If yes, what types of medical assistance does each person need? Read the descriptions below. Check the boxes for all programs each person needs. KanCare will tell you if you qualify.</p>		

This is the top of page 5, where it continues to ask about Person 1 through Person 3. As a reminder, if there are more than 3 people living in the household, the applicant will need to copy pages 4-12.

The first question that is asked in this section is “Was this person in Kansas foster care on their 18th birthday?” Check “No” or “Yes”.

The next question asks “Is this person applying for medical assistance?” This is where the applicant will check “No” or “Yes” under each ‘Person’ who is on the application. It is very important to answer “No” or “Yes” for each person on the application.

► If yes, what types of medical assistance does each person need? Read the descriptions below. Check the boxes for all programs each person needs. KanCare will tell you if you qualify.

- | | | |
|--|--|--|
| <input type="checkbox"/> Standard Medicaid (with medical card) | <input type="checkbox"/> Standard Medicaid (with medical card) | <input type="checkbox"/> Standard Medicaid (with medical card) |
| <input type="checkbox"/> HCBS (includes assisted living) | <input type="checkbox"/> HCBS (includes assisted living) | <input type="checkbox"/> HCBS (includes assisted living) |
| <input type="checkbox"/> Nursing home or other facility | <input type="checkbox"/> Nursing home or other facility | <input type="checkbox"/> Nursing home or other facility |
| <input type="checkbox"/> PACE | <input type="checkbox"/> PACE | <input type="checkbox"/> PACE |
| <input type="checkbox"/> Medicare costs only (no other KanCare assistance) | <input type="checkbox"/> Medicare costs only (no other KanCare assistance) | <input type="checkbox"/> Medicare costs only (no other KanCare assistance) |
| <input type="checkbox"/> Medically Needy (Spenddown) | <input type="checkbox"/> Medically Needy (Spenddown) | <input type="checkbox"/> Medically Needy (Spenddown) |
| <input type="checkbox"/> Working Healthy | <input type="checkbox"/> Working Healthy | <input type="checkbox"/> Working Healthy |

Types of medical assistance

Home and Community Based Services (HCBS) is for children with disabilities and elderly or disabled adults who have a medical need for services in the community so they can live at home or in assisted living.

Nursing home or other facility is for children with disabilities and elderly or disabled adults who live in a nursing home, medical or mental health institution, or similar facility for a long-term stay.

Program of All-Inclusive Care for the Elderly (PACE) is for adults who live in certain counties and are age 65 or older or are disabled and age 55 or older. Persons who qualify get long-term care coverage through a managed care network so they can stay in the community.

Medicare Savings Program (Medicare costs) is for people who have Medicare. This program pays the Medicare Part B premiums. It may also pay Medicare co-payments and deductibles.

Medically Needy (Spenddown) is for persons in the community who have a disability or are age 65 or older. It uses medical expenses to "spend down" (lower) your income so you qualify for Medicaid.

Working Healthy is for people with disabilities who qualify. It helps them get or keep Medicaid coverage while working.

If "Yes" was checked under "Is this person applying for medical assistance" then the applicant will need to check the box for the programs they think will best fit their needs.

The applicant is free to check more than one box if they think that program will help them. We will tell the applicant if they qualify.

Next, we will go through each program in better detail in the order that it is listed above.



For those who:

- Need medical assistance.
- Do not know which program box to check.

Standard Medicaid with a medical card is for those who need medical assistance or do not know which program box to check.

Applicants can also check the “Standard Medicaid” box if they do not know which program would best fit their needs. We will look at possible medical coverage options.



Also known as the HCBS Waiver Program

- Receives Standard Medicaid.
- May pay for a in home care attendant to help with activities of daily living based on the person's needs.
- Is meant for people living at home, renting, staying with family, in assisted living, or home plus.
- This program is not for those who live in a Nursing Facility.

You can find additional information about each waiver at:

<https://kancare.ks.gov/kancare-ombudsman-office/hcbs-waiver-fact-sheets>

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Home and Community Based Services are also known as the HCBS Waiver Program which may include:

- Standard Medicaid.
- Payment for a in home care attendant to help with activities of daily living based on the person's needs.

HCBS is meant for people living at home, renting, staying with family, in assisted living, or home plus. This program is not for those who live in a Nursing Facility.

There are 7 Home and Community Based Service Waivers, each with their own set of rules and eligibility guidelines. Select this option if the applicant is applying for Home and Community Based Services, or HCBS. The 7 HCBS Waivers are:

1. Autism Waiver
2. Frail Elderly Waiver

3. Intellectual/Developmental Disabilities Waiver
4. Physical Disability Waiver
5. Serious Emotional Disturbance Waiver
6. Technology Assisted Waiver
7. Brain Injury Waiver

See the link at the bottom of this slide for more information about each waiver.

<https://kancare.ks.gov/kancare-ombudsman-office/hcbs-waiver-fact-sheets>



This is for:

- For people who are currently living in a Nursing Facility, mental health institution, or similar facility for a long-term stay.

This is not for:

- Those in Assisted Living facilities.
- Those in a Home Plus facilities.

To learn more about how to calculate a Monthly Patient Liability go to:

<https://kancare.ks.gov/kancare-ombudsman-office/resources>

Nursing Home or other institutional coverage is for those living in a nursing facility, mental health institution, or similar facility for a long term stay. If eligible for this program, the member may have to pay what is called a Patient Liability. This is also known as the cost share for Nursing Home coverage.

If the applicant lives in a facility that has assisted living and skilled nursing, it is important to know which section of the facility the person is in. All Home Plus facilities are considered an Assisted Living Facility. Home Plus and Assisted Living residents need to apply for a Home and Community Based Services (HCBS) Waiver Program.

<https://kancare.ks.gov/kancare-ombudsman-office/resources>



This program is for:

- Persons aged 55 and older.
- Who need a nursing home-level of care.
- Can live safely in the community with the help of PACE services.
- Live in the service area of a PACE organization.

For more information about the PACE program go to:

[https://kdads.ks.gov/commissions/commission-on-aging/program-of-all-inclusive-care-for-the-elderly-\(pace\)](https://kdads.ks.gov/commissions/commission-on-aging/program-of-all-inclusive-care-for-the-elderly-(pace))

Program of All-Inclusive Care for the Elderly, or PACE, is for persons aged 55 and older and who need a nursing home-level of care but can live safely in the community with the help of PACE services.

To be eligible for this program, applicants will need to live in a service area of a PACE organization. This information can be found by clicking this link.

[https://kdads.ks.gov/commissions/commission-on-aging/program-of-all-inclusive-care-for-the-elderly-\(pace\)](https://kdads.ks.gov/commissions/commission-on-aging/program-of-all-inclusive-care-for-the-elderly-(pace))



This program is for:

- People who have Medicare and need help with Medicare’s premiums and other out-of-pocket expenses.

Check this box only if you want MSP, no other programs. If this box is not checked, the applicant will automatically be screened for MSP.

For more information on MSP see:

<https://kancare.ks.gov/kancare-ombudsman-office/kancare-general-information-fact-sheets>

The Medicare Savings Program or MSP is a program that helps Medicare recipients with their out of pocket medical expenses, for example: Medicare premiums and copays.

The Medicare Savings Program is not subject to Estate Recovery. If this box is checked, it means the eligibility team will only check for eligibility under the Medicare Savings Program.

Check this box only if the applicant wants MSP, no other programs. If this box is left unchecked, the applicant will be automatically screened for MSP.

If the applicant is almost 65 or will soon become eligible for Medicare, they can apply for MSP so that it may be started at the same time that Medicare begins.

<https://kancare.ks.gov/kancare-ombudsman-office/kancare-general-information-fact-sheets>



This program is for:

- The elderly (age 65 and over)
- Persons with disabilities

This program is for individuals who make too much income to qualify for Medicaid but qualify anyway because they have consistently high medical bills that will likely impoverish them without the state’s assistance.

They are Medicaid eligible **“with a Spendedown.”**

For more information see: <https://kancare.ks.gov/consumers/program-fact-sheets>

The medically needy program is for people who are 65 and older or have a disability. This program is for individuals who make too much income to qualify for Medicaid but qualify anyway because they have consistently high medical bills that will likely impoverish them without the state’s assistance.

They are Medicaid eligible “with a Spendedown.” A spenddown is like an insurance deductible, which means a person must incur medical costs up to a set amount before their health insurance provider will pay. When the spenddown is met, Medicaid will pay for covered medical expenses until the next Spendedown period. Spendedown amounts are dependent on the household countable income.

For more information about the Medically Needy Program see the link at the bottom of this slide.

<https://kancare.ks.gov/consumers/program-fact-sheets>



This program is for:

- Those who are working or thinking about going to work or wanting to work.
- Those who have a disability.

Working Healthy is a work incentive program designed for people who are only eligible for Medically needy. This program substitutes the Spenddown with an affordable premium.

Based on income level, some individuals may have to pay a monthly premium.

For more information about the Working Healthy program see: <https://kancare.ks.gov/consumers/working-healthy>

Working healthy is for those who are working or thinking about going to work or wanting to work and have a disability.

Working Healthy is a work incentive program designed for people who are only eligible for Medically Needy. This program substitutes the Spenddown with an affordable premium.

This program is based on income level and some individuals may have to pay a monthly premium.

For more information about the Working Healthy program see the link at the bottom of the screen.

<https://kancare.ks.gov/consumers/working-healthy>

Pg. 5, Sec. B

► If yes, what types of medical assistance does each person need? Read the descriptions below. Check the boxes for all programs each person needs. KanCare will tell you if you qualify.

- | | | |
|--|--|--|
| <input type="checkbox"/> Standard Medicaid (with medical card) | <input type="checkbox"/> Standard Medicaid (with medical card) | <input type="checkbox"/> Standard Medicaid (with medical card) |
| <input type="checkbox"/> HCBS (includes assisted living) | <input type="checkbox"/> HCBS (includes assisted living) | <input type="checkbox"/> HCBS (includes assisted living) |
| <input type="checkbox"/> Nursing home or other facility | <input type="checkbox"/> Nursing home or other facility | <input type="checkbox"/> Nursing home or other facility |
| <input type="checkbox"/> PACE | <input type="checkbox"/> PACE | <input type="checkbox"/> PACE |
| <input type="checkbox"/> Medicare costs only (no other KanCare assistance) | <input type="checkbox"/> Medicare costs only (no other KanCare assistance) | <input type="checkbox"/> Medicare costs only (no other KanCare assistance) |
| <input type="checkbox"/> Medically Needy (Spenddown) | <input type="checkbox"/> Medically Needy (Spenddown) | <input type="checkbox"/> Medically Needy (Spenddown) |
| <input type="checkbox"/> Working Healthy | <input type="checkbox"/> Working Healthy | <input type="checkbox"/> Working Healthy |

Types of medical assistance

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Program of All-Inclusive Care for the Elderly (PACE) is for adults who live in certain counties and are age 65 or older or are disabled and age 55 or older. Persons who qualify get long-term care coverage through a managed care network so they can stay in the community.

Medicare Savings Program (Medicare costs) is for people who have Medicare. This program pays the Medicare Part B premiums. It may also pay Medicare co-payments and deductibles.

Medically Needy (Spenddown) is for persons in the community who have a disability or are age 65 or older. It uses medical expenses to "spend down" (lower) your income so you qualify for Medicaid.

Working Healthy is for people with disabilities who qualify. It helps them get or keep Medicaid coverage while working.

The applicant should take the time to go back and check the boxes next to the program or programs for each applicant that is applying for medical assistance.

Now that we have briefly gone over the types of medical assistance on page 5, we are ready to move on to page 6.



Page 6: KC-1500: Section B continued, Social Security, and Citizenship

Pg. 6

Person 1 (continued)	Person 2 (continued)	Person 3 (continued)
First and last name	First and last name	First and last name
<p>B</p> <p>We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. Use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are not applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call 1-800-772-4213 or visit www.socialsecurity.gov. If you don't give your SSN, you can still apply.</p>		
<p>What is this person's Social Security Number?</p>		
Social Security Number	Social Security Number	Social Security Number
-----	-----	-----
<p>is this person a U.S. citizen or U.S. national? Must answer if applying for medical assistance.</p>		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>is this person a naturalized or derived citizen? (This usually means you were born outside the U.S.)</p>		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<p>► If yes, tell us this person's alien number and certificate number.</p>		
Alien number (optional)	Alien number (optional)	Alien number (optional)
-----	-----	-----
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
-----	-----	-----
<p>if this person is not a U.S. citizen or U.S. national, do they have eligible immigration status?</p>		
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<p>► If yes, tell us more about this person's immigration status.</p>		
Document type	Document type	Document type
-----	-----	-----
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
-----	-----	-----
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
-----	-----	-----
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
-----	-----	-----
Card number or passport number	Card number or passport number	Card number or passport number
-----	-----	-----
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
-----	-----	-----
Other (category code or country where issued)	Other (category code or country where issued)	Other (category code or country where issued)
-----	-----	-----

This is the sixth page of the paper application for the Elderly and Persons with Disabilities. Next, we will go through each part of the sixth page, this is also a continuation of Section B. On page 6, applicants are asked for information about Citizenship and Identity.

Person 1 (continued)	Person 2 (continued)	Person 3 (continued)
First and last name	First and last name	First and last name
<p>We need Social Security Numbers (SSNs) for anyone applying for medical assistance who has or can get an SSN. We use SSNs to check income and other information to see who qualifies for help with medical assistance. Household members who are not applying for medical assistance do not have to give their SSNs. But if we have their SSNs, the application process may go faster. If someone doesn't have an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. If you don't give your SSN, you can still apply.</p>		
<p>What is this person's Social Security Number?</p>		
Social Security Number	Social Security Number	Social Security Number
____-____-____	____-____-____	____-____-____

We need a Social Security Number for those requesting medical coverage and have a Social Security Number or can get one.

A Social Security Number is optional for people not applying for medical assistance, but providing a Social Security Number can speed up the application process. Social Security Numbers are used to check income and other information to see who is eligible for help paying for health coverage.

If someone doesn't have a Social Security Number call 1-800-772-1213 or visit www.socialsecurity.gov

Pg. 6, Sec. B

Is this person a U.S. citizen or U.S. national? Must answer if applying for medical assistance.		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this person a naturalized or derived citizen? (This usually means you were born outside the U.S.)		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
► If yes, tell us this person's alien number and certificate number.		
Alien number (optional)	Alien number (optional)	Alien number (optional)
Certificate number (optional)	Certificate number (optional)	Certificate number (optional)
If this person is not a U.S. citizen or U.S. national, do they have eligible immigration status?		
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
► If yes, tell us more about this person's immigration status.		
Document type	Document type	Document type
Immigration status (optional)	Immigration status (optional)	Immigration status (optional)
Name as it appears on immigration document	Name as it appears on immigration document	Name as it appears on immigration document
Alien or I-94 number	Alien or I-94 number	Alien or I-94 number
Card number or passport number	Card number or passport number	Card number or passport number
SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)	SEVIS ID or expiration date (optional)
Other (category code or country where issued)	Other (category code or country where issued)	Other (category code or country where issued)

This part on page 6 asks about the citizenship and immigration status of each person in the household. The applicant should fill this out to the best of their ability.

For the question “If this person is not a U.S. citizen or U.S. national, do they have eligible immigration status?”, if “Yes” mark it “Yes”, otherwise, leave blank.



Page 7 : KC-1500: Section B continued, Race and Ethnicity

Pg. 7

Person 1 (continued)	Person 2 (continued)	Person 3 (continued)																																													
First and last name	First and last name	First and last name																																													
<p>Has this person lived in the U.S. since 1996?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes</p>																																															
<p>What is this person's race? Check all that apply. This question is optional. You do not have to answer.</p> <table border="0"> <tr> <td><input type="checkbox"/> American Indian or Alaska Native</td> <td><input type="checkbox"/> American Indian or Alaska Native</td> <td><input type="checkbox"/> American Indian or Alaska Native</td> </tr> <tr> <td><input type="checkbox"/> Asian Indian</td> <td><input type="checkbox"/> Asian Indian</td> <td><input type="checkbox"/> Asian Indian</td> </tr> <tr> <td><input type="checkbox"/> Black</td> <td><input type="checkbox"/> Black</td> <td><input type="checkbox"/> Black</td> </tr> <tr> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> Chinese</td> </tr> <tr> <td><input type="checkbox"/> Filipino</td> <td><input type="checkbox"/> Filipino</td> <td><input type="checkbox"/> Filipino</td> </tr> <tr> <td><input type="checkbox"/> Guamanian or Chamorro</td> <td><input type="checkbox"/> Guamanian or Chamorro</td> <td><input type="checkbox"/> Guamanian or Chamorro</td> </tr> <tr> <td><input type="checkbox"/> Japanese</td> <td><input type="checkbox"/> Japanese</td> <td><input type="checkbox"/> Japanese</td> </tr> <tr> <td><input type="checkbox"/> Korean</td> <td><input type="checkbox"/> Korean</td> <td><input type="checkbox"/> Korean</td> </tr> <tr> <td><input type="checkbox"/> Native Hawaiian</td> <td><input type="checkbox"/> Native Hawaiian</td> <td><input type="checkbox"/> Native Hawaiian</td> </tr> <tr> <td><input type="checkbox"/> Other Asian</td> <td><input type="checkbox"/> Other Asian</td> <td><input type="checkbox"/> Other Asian</td> </tr> <tr> <td><input type="checkbox"/> Samoan</td> <td><input type="checkbox"/> Samoan</td> <td><input type="checkbox"/> Samoan</td> </tr> <tr> <td><input type="checkbox"/> Other Pacific Islander</td> <td><input type="checkbox"/> Other Pacific Islander</td> <td><input type="checkbox"/> Other Pacific Islander</td> </tr> <tr> <td><input type="checkbox"/> Vietnamese</td> <td><input type="checkbox"/> Vietnamese</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td><input type="checkbox"/> White</td> <td><input type="checkbox"/> White</td> <td><input type="checkbox"/> White</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> </tr> </table>			<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Black	<input type="checkbox"/> Black	<input type="checkbox"/> Black	<input type="checkbox"/> Chinese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Chinese	<input type="checkbox"/> Filipino	<input type="checkbox"/> Filipino	<input type="checkbox"/> Filipino	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Japanese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Korean	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Samoan	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> American Indian or Alaska Native																																													
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<input type="checkbox"/> Black	<input type="checkbox"/> Black	<input type="checkbox"/> Black																																													
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<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Guamanian or Chamorro																																													
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<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Native Hawaiian																																													
<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Asian																																													
<input type="checkbox"/> Samoan	<input type="checkbox"/> Samoan	<input type="checkbox"/> Samoan																																													
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other Pacific Islander																																													
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Vietnamese																																													
<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White																																													
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other																																													
<p>What is this person's ethnicity? If Hispanic or Latino ethnicity, check all that apply. This question is optional. You do not have to answer.</p> <table border="0"> <tr> <td><input type="checkbox"/> Cuban</td> <td><input type="checkbox"/> Cuban</td> <td><input type="checkbox"/> Cuban</td> </tr> <tr> <td><input type="checkbox"/> Mexican</td> <td><input type="checkbox"/> Mexican</td> <td><input type="checkbox"/> Mexican</td> </tr> <tr> <td><input type="checkbox"/> Mexican American Chicano/a</td> <td><input type="checkbox"/> Mexican American Chicano/a</td> <td><input type="checkbox"/> Mexican American Chicano/a</td> </tr> <tr> <td><input type="checkbox"/> Puerto Rican</td> <td><input type="checkbox"/> Puerto Rican</td> <td><input type="checkbox"/> Puerto Rican</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> </tr> </table>			<input type="checkbox"/> Cuban	<input type="checkbox"/> Cuban	<input type="checkbox"/> Cuban	<input type="checkbox"/> Mexican	<input type="checkbox"/> Mexican	<input type="checkbox"/> Mexican	<input type="checkbox"/> Mexican American Chicano/a	<input type="checkbox"/> Mexican American Chicano/a	<input type="checkbox"/> Mexican American Chicano/a	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other																														
<input type="checkbox"/> Cuban	<input type="checkbox"/> Cuban	<input type="checkbox"/> Cuban																																													
<input type="checkbox"/> Mexican	<input type="checkbox"/> Mexican	<input type="checkbox"/> Mexican																																													
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<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Puerto Rican																																													
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other																																													

For help completing this application, call us at 1-800-792-4884 (TTY 1-800-792-4292). The call is free.

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This is the seventh page of the paper application for the Elderly and Persons with Disabilities.

The first question on this page asks "Has this person lived in the U.S. since 1996?" check "Yes" or "No"

The next two questions that ask about race and ethnicity are optional and more than one box may be checked.



Page 8: KC-1500: Section B continued, Living Situation, and Medical Expenses

Pg. 8

B

Person 1 (continued) First and last name	Person 2 (continued) First and last name	Person 3 (continued) First and last name
Which of these best describes where the person lives now?		
<input type="checkbox"/> Own home	<input type="checkbox"/> Own home	<input type="checkbox"/> Own home
<input type="checkbox"/> Renting	<input type="checkbox"/> Renting	<input type="checkbox"/> Renting
<input type="checkbox"/> Live with someone else	<input type="checkbox"/> Live with someone else	<input type="checkbox"/> Live with someone else
<input type="checkbox"/> Assisted living	<input type="checkbox"/> Assisted living	<input type="checkbox"/> Assisted living
<input type="checkbox"/> Nursing facility or other institution	<input type="checkbox"/> Nursing facility or other institution	<input type="checkbox"/> Nursing facility or other institution
<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
Is this person living outside of the home?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
► If yes, why is this person living outside of the home?		
Reason	Reason	Reason
Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /
► If in a hospital, nursing facility or other institution, what is the name of the facility?		
Name of facility	Name of facility	Name of facility
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /
Does this person pay out of pocket for medical expenses not covered by Medicare, Medicaid or private insurance?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
► If yes, tell us about the expense:		
How much? \$	How much? \$	How much? \$
How often?	How often?	How often?
Describe the expense:	Describe the expense:	Describe the expense:

© KanCare | Elderly and Persons with Disabilities Medical Assistance Application

This is the eighth page of the paper application for the Elderly and Persons with Disabilities. Next, we will go through each part of the eighth page. This is also a continuation of Section B.

Person 1 (continued)	Person 2 (continued)	Person 3 (continued)
First and last name	First and last name	First and last name
Which of these best describes where the person lives now?		
<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted living <input type="checkbox"/> Nursing facility or other institution <input type="checkbox"/> Hospital <input type="checkbox"/> Other	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted living <input type="checkbox"/> Nursing facility or other institution <input type="checkbox"/> Hospital <input type="checkbox"/> Other	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Live with someone else <input type="checkbox"/> Assisted living <input type="checkbox"/> Nursing facility or other institution <input type="checkbox"/> Hospital <input type="checkbox"/> Other

The first question on page 8 asks “Which of these best describes where the person lives now?” The applicant will check the box for the living situation for each person on the application.

If the applicant lives in a facility that has assisted living and skilled nursing, it is important to know which section of the facility the person is in.

If the person is homeless, mark “Other”.

Is this person living outside of the home?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, why is this person living outside of the home?		
Reason	Reason	Reason
Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /	Date expected to return (mm/dd/yyyy) / /
▶ If in a hospital, nursing facility or other institution, what is the name of the facility?		
Name of facility	Name of facility	Name of facility
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /

The next question on page 8 asks, “Is this person living outside of the home?” If the person is currently living outside of the home (such as a Nursing Facility or similar Long-Term Care institution), applicants will need to fill out the information in this section.

If applicants do not know the date expected to return, they can put N/A.

Does this person pay out of pocket for medical expenses not covered by Medicare, Medicaid or private insurance?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, tell us about the expenses.		
How much? \$	How much? \$	How much? \$
How often?	How often?	How often?
Describe the expense:	Describe the expense:	Describe the expense:

The last question on page 8 asks, “Does this person pay out of pocket for medical expenses not covered by Medicare, Medicaid, or private insurance?”

If the person applying for medical assistance has recurring or outstanding medical expenses, then they may check ‘yes’ and give information about each expense.

If more room is needed please, feel free to attach additional pieces of paper with the application that has the cost, how often it is paid, and a description of the medical expense.



Page 9: KC-1500 : Section B continued, Nursing Facility, Military, and Pregnancy

Pg. 9

Person 1 (continued) First and last name	Person 2 (continued) First and last name	Person 3 (continued) First and last name
Has this person ever been in a hospital or nursing facility for more than 30 days in a row?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, when? (mm/dd/yyyy)		
Date admitted / /	Date admitted / /	Date admitted / /
Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /	Date or estimated date of discharge (if known) / /
Has this person served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
VA file number	VA file number	VA file number
If this person has not served in the military, has this person ever been married to someone who has served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, is this person a widow or widower of someone who served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, has this person remained unmarried after the death of the spouse who served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this person pregnant?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, how many babies are expected?		
/ /		
▶ If yes, what is the expected due date? Estimate if unknown. (mm/dd/yyyy) This question is optional. You do not have to answer.		
/ /		

For help completing this application, call us at 1-800-792-4884 (TTY 1-800-792-4292). The call is free.

This is the ninth page of the paper application for the Elderly and Persons with Disabilities. Next, we will go through each part of the ninth page. This is also a continuation of Section B.

B		
Person 1 (continued)	Person 2 (continued)	Person 3 (continued)
First and last name	First and last name	First and last name
Has this person ever been in a hospital or nursing facility for more than 30 days in a row?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
► If yes, when? (mm/dd/yyyy)		
Date admitted	Date admitted	Date admitted
/ /	/ /	/ /
Date or estimated date of discharge (if known)	Date or estimated date of discharge (if known)	Date or estimated date of discharge (if known)
/ /	/ /	/ /

The first question on page 9 asks “Has this person ever been in a hospital or nursing facility for more than 30 days in a row?” This is for people who have stayed in a facility in the past.

If yes, when? Please list the first admission and discharge date. It is okay to write the Month and Year for the admission and discharge dates. If the dates are unknown, please provide the best guess.

This question is specific to an applicant who has a spouse and the applicant is requesting nursing home, PACE, or HCBS coverage. We will need to know the applicants first 30 day stay in a hospital or nursing home. This will determine the month and year they request resources to determine how much a spouse can protect of a couple’s resources.

Has this person served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
VA file number	VA file number	VA file number
If this person has not served in the military, has this person ever been married to someone who has served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes , is this person a widow or widower of someone who served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes , has this person remained unmarried after the death of the spouse who served in the military?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

For help with these questions see the Kansas Commission on Veterans Affairs office at:

<https://kcva.ks.gov/veteran-services/office-locations>

The next set of questions on page 9 asks if the people applying for medical assistance have served in the military.

If the applicant served in the military, there is potential for a cash benefit from the Veteran Administration. It is required that veterans apply for VA benefits. We must have proof the applicant has applied with the VA. To apply, contact the Veteran’s Administration at 1-800-827-1000, or the Kansas Commission of Veteran’s Affairs at 785-296-3976.

The next question asks, “If this person has not served in the military, has this person ever been married to someone who has served in the military?” This question and the two under it are ‘yes’ or ‘no’ questions.

Is this person pregnant?					
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
▶ If yes , how many babies are expected?					
▶ If yes , what is the expected due date? Estimate if unknown. (mm/dd/yyyy) <i>This question is optional. You do not have to answer.</i>					
	/	/		/	/

At the bottom of page 9 it asks if anyone is pregnant, how many babies are expected, and what the expected due date is.



Page 10: KC-1500: Section C, Help with Medical Bills

Pg. 10

c Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July. Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for you and all others who are applying (Person 2, Person 3, etc.).

Person 1 (continued) First and last name	Person 2 (continued) First and last name	Person 3 (continued) First and last name
Does this person need help paying medical bills from the last 3 months, including Medicare premiums?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did this person have emergency care in the last 3 months to save life, organs or bodily function?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has this person lived in a state other than Kansas in the last 3 months?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

Tell us about changes in your household

Has your household size changed in the last 3 months because someone moved in or out?

No Yes: if yes, tell us about the changes to your household:

Has your household income changed in the last 3 months?

No Yes: if yes, tell us about the changes to your income:

Have your household resources changed in the last 3 months?

No Yes: if yes, tell us about the changes to your resources:

This is the tenth page of the paper application for the Elderly and Persons with Disabilities. Next, we will go through each part of the tenth page. Page 10 is also Section C.

C Help with medical bills in the past 3 months

These questions ask about medical bills and where you lived in the 3 months before the month you are applying. For example, if you are applying in August, these questions are about May, June, and July.

Your answers help us decide if you qualify for coverage for those 3 months. We also check to see if non-citizens qualify for certain emergency services.

Answer the questions for you and all others who are applying (Person 2, Person 3, etc.).

Person 1 (continued)	Person 2 (continued)	Person 3 (continued)
First and last name	First and last name	First and last name
Does this person need help paying medical bills from the last 3 months, including Medicare premiums?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did this person have emergency care in the last 3 months to save life, organs or bodily function?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has this person lived in a state other than Kansas in the last 3 months?		
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
▶ If yes, when did this person move to Kansas? (mm/dd/yyyy)		
/ /	/ /	/ /

The top of page 10 asks questions about the past 3 months of medical bills for each person applying for medical assistance.

Applicants may qualify for coverage up to 3 months prior to the application month if otherwise eligible.

The question “Does this person need help paying medical bills from the last 3 months, including Medicare premiums?” is important because if you mark "no", we will not look for eligibility in the months prior to the application month.

Tell us about changes in your household	
Has your household size changed in the last 3 months because someone moved in or out?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tell us about the changes to your household:
Has your household income changed in the last 3 months?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tell us about the changes to your income:
Have your household resources changed in the last 3 months?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tell us about the changes to your resources:

The last set of questions at the bottom of page 10 ask about changes in your household in the past 3 months.

If the applicant has asked for help paying for past medical bills at the top of page 10, then these questions must be answered.



A Guide to Completing the KC-1500 Application

For the Elderly and Persons with Disabilities



Sections A, B, & C



This guide was created in partnership with the KanCare Ombudsman Office and the Kansas Department of Health and Environment.

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Thank you for looking at the second slideshow of the KanCare Application Guide for the Elderly and Persons with Disabilities Medical Assistance Application. In the third video, we will go over Section D, E, & F of the application.